Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS5152ADC	A. BUILDING: _____ B. WING _____	03/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BABY BOOMER'S ACTIVITIES CLUB, LLC	850 S JONES LAS VEGAS, NV 89107

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
U 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the State Licensure survey conducted at your facility on 3/18/15. The survey was conducted using Nevada Administrative Code (NAC) 449, Facilities For Care Of Adults During The Day, regulations adopted by the Nevada State Board of Health on June 23, 1986. The facility was licensed for 70 total day care clients. The census at the time of the survey was 48. Fifteen resident files were reviewed and ten employee files were reviewed. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	U 000		
U247 SS=F	449.4088 Plan of Care 3. An assessment of each client's needs in relation to his plan of care must be conducted at least once every 3 months and included in the client's file. This Regulation is not met as evidenced by: Based on record review and interview, the facility failed to ensure 15 of 15 clients had a quarterly assessment. (Clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14 and #15).	U247		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

04/10/15

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U247	Continued From page 1 Findings include: On 3/18/15/15, a review of client files revealed the following: -The files for Clients #1 through #15 lacked documented evidence of a quarterly assessment of each client's needs in relation to their plan of care. On 3/18/15 at 4:45 PM, the Administrator acknowledged the missing assessments. Severity: 2 Scope: 3	U247		